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A. OUTPATIENT HOSPITAL AND OTHER SERVICES

1. Except for emergency room, lithotripsy, Federally Qualified Health Centers, laboratory and radiology services, the payment level for outpatient hospital claims will be based on 77% allowed charges for urban hospitals and 93% allowed charges for rural hospitals.
2. Payments for emergency room services vary depending on urban/rural designation and whether the service is designated as "emergency" or "non-emergency". The "emergency designation is based on the principal diagnosis (ICD-9 Codes). Rural hospitals will receive 98% of charges for emergency services and 65% for non-emergency use of the emergency room. Urban hospitals will receive 98% of charges for emergencies and 40% of charges for non-emergency use of the emergency room.
3. Payment for lithotripsy services is a fixed fee of $2,800. The $2,800 fee is all inclusive except for physician services that are billed on the HCFA-1500. The rate includes all services related to lithotripsy on the same kidney for 90 days. No additional payment will be made for repeat procedures on the same kidney within the 90 day period. Treatment of the kidney on the opposite side will be paid as a separate treatment, but is also subject to the 90 day restriction. The payment rate will be reviewed and updated annually using economic trends and conditions.
4. Payment for laboratory and radiology services provided in a hospital to outpatients will be made based on HCPCS codes and an established fee schedule, unless a lesser amount is billed. The fee schedule used to pay physicians is used to establish payment rates.
5. Billed charges shall not exceed the usual and customary charge to private pay patients.
6. Payments for all outpatient services are limited to the aggregate annual amount Medicare would pay for the same services as required by 42 CFR 447.321.
7. Payments to Federally Qualified Health Centers are based on an annual retrospective cost settlement using Medicare reimbursement principles. This settlement consists of first, determining allowable costs using Medicare definitions, and second, allocating costs to Medicaid. This allocation method may vary, depending on the type of FQHC.
8. Payments for physical therapy/occupational therapy are based on the established fee schedule unless a lower amount is billed. Fees are established by discounting historical charges, by professional judgement, and by the physical therapy and occupational therapy fee schedule. Since the amount of physical therapy and occupational therapy is limited, the select case management committee of the facility will determine which type of service (physical therapy or occupational therapy) should be provided for the patient by the facility. The amount of physical therapy provided will affect the amount of occupational therapy available, and vice versa.

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A. OUTPATIENT HOSPITAL AND OTHER SERVICES (Continued)

FEDERALLY FUNDED HEALTH CENTER (FFHC)

Costs are allocated to Medicaid using the percentage of aggregate Medicaid billed charges to total charges for all patients. Allowable costs are multiplied by the Medicaid percentage to arrive at the amount of allowable cost to be paid by Medicaid. Interim payments will be made for each claim processed by Medicaid. Third party collections for Medicaid patients will be subtracted from the allocated costs in completing the cost settlement.

RURAL HEALTH CENTER

Rural health clinics may continue to use the Medicare cost finding principles. These cost finding principles use the average cost per visit to determine payments. The reimbursement methodology is described in 42 CFR 447.371.

42 CFR 440.30 C. LABORATORY AND RADIOLOGY SERVICES

Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed the usual and customary charge to private pay patients. Payment will not exceed the Medicare fee schedule as required by Section 2303 of P. L. 98-369.

42 CFR D. PHYSICIANS (Except Anesthesiologists)

1. INTRODUCTION

Payment will be based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. In establishing the fee schedule, a single fee is established for each procedure code regardless of provider specialty.

2. FEE SCHEDULE BASED ON RELATIVE VALUES

The physician fee schedule is based on relative value units unless otherwise specified in the "Alternative Fees Section." Weight for the CPT Codes are based on the 1994 Resource Based Relative Value Scale (RBRVS) published by HCFA. Special payment considerations are given for EPSDT services. When compared to billed charges, the annual payment for EPSDT services are approximately 25% higher than payments for other physician services. Similarly, maternity codes covering deliveries are priced higher in response to OBRA requirements.
Physicians practicing in rural areas of the State are paid an additional 12%. Rural areas are defined as those areas in Utah outside of Wasatch Front -- Davis, Weber, Utah and Salt Lake counties.

3. ALTERNATIVE FEES

When an RVS value is either not available or not appropriate, an alternative method will be used to establish the fee. In establishing alternative fees, reference will be made to the methodology included in the Medicare regulations covering "gap filling" for physician fees. In addition to professional judgments, consideration will be given to one or more of the following:



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a. Utah Medical payment history;
b. Medicare fees;
c. Practitioner fee schedules;
d. Fee schedules from other states;
e. Similar procedures with established fees;
f. Medical determinations by physician consultants, and
g. Private insurance payments.

There are some fees that are seldom billed and services that do not fit into the routine HCPCS coding structure. When it is not practical to establish a specific fee, payments may be determined by either calculating a percent of billed charges or by using the professional judgment of a physician consultant. The percent of billed charges is determined by projecting the average percent of billed charges paid for surgery codes at the end of the fiscal year.

4. ECONOMIC INDEX

An economic index may be used to adjust the fee schedule. Each year the Department of Health will specify the economic indices. Input from the providers and the Medical Care Advisory Committee will be considered in determining the increase.

5. MULTIPLE AND BI-LATERAL PROCEDURES

The primary surgical procedures with the highest payment rate is paid based on 100% of the established Medicaid fee, the second highest payment rate is paid based on 50% of the established fee schedule. Payment for the other lower payment rates is made at 25% of the established fee schedule for multiple and bi-lateral procedures. When CPT modifiers are used, the rate is adjusted for CPT modifiers before the percentages are applied for multiple and bi-lateral procedures. Provision is made for multiple units billed for designated procedure codes to pay at 100% of the established Medicaid fee schedule. For example, code 15101 provides a fee to be paid for each 100 square centimeters of skin transplant. Such designated procedures are paid at 100% of the established fee regardless of the number of times that the code is billed.



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6. SPECIAL MODIFIERS

Modifiers are described in the CPT-4 manual and incorporated in HCPCS. Physicians should bill usual and customary charges for their services. Usual and customary charges should reflect normal reductions for "reduced services" in accordance with normal billing practices. Payment for modifiers will be limited as follows:

a. Modifier "22" is suspended for manual pricing when there is an accompanying post-operative report.
b. Modifier "26" has a separate fee in the payment schedule and pays according to the established fee schedule.
c. Modifier "50" for bilateral procedures is paid as discussed in Section D-5 of this ATTACHMENT - Multiple and Bilateral Procedures.
d. Modifier "51" for multiple procedures is paid as discussed in Section D-5 of this ATTACHMENT - Multiple and Bilateral Procedures.
e. Modifier "52" for reduced service is paid at 50 percent of the established fee schedule.
f. Modifier "53" for a discontinued procedure is paid at 50 percent of the established fee schedule.
g. Modifier "54" is paid at 80 percent of the established fee schedule.
h. Modifier "55" is paid at 20 percent of the established fee schedule.
i. Modifier "56" is paid at 20 percent of the established fee schedule.
j. Modifier "62" is paid at 62.5 percent of the established fee schedule.
k. Modifier "66" is suspended for manual review and is priced by Medicaid physician consultants.
l. Modifier "76" is paid at 100 percent of the established fee schedule.
m. Modifier "77" is paid at 100 percent of the established fee schedule.
n. Modifier "80" for assistant surgeon is limited to 20 percent of the established Medicaid fee schedule.
o. Modifier "81" for minimum assistant surgeon is limited to 15 percent of the established Medicaid fee schedule.

7. ENHANCED PAYMENT RATES

Physicians providing services in rural areas of the state and physicians employed by public teaching institutions in urban areas are paid a rate differential equal to 112 percent of the physician fee schedule. Rural areas are defined as areas of the State of Utah outside of Weber, Davis, Salt Lake, and Utah counties.

8. RATE ADJUSTMENT -- ACCESS

To improve client access to physicians, payments are increased to providers who render significant services to Medicaid clients. Significant services are defined as total annual relative value units (RVUs) times .2698 and the resulting product being greater than $100. The payment to each qualifying provider is the annual RVUs times .2698. For example, if the annual RVUs for Dr. Jones are 1,500 units, the payment would be $404.70.

42 CFR 440.50 and 440.60

E. ANESTHESIOLOGIST/ANESTHETIST

INTRODUCTION

Payment is based on the lower of billed usual and customary charges or a calculated fee. Beginning with dates of service on and after February 1, 1995, anesthesiology service is billed and paid under a new system. This new system is based on the 1994 Relative Value Guide published by the American Society of Anesthesiologists (ASA). The initial Medicaid rate is $14.10. During the first three months of operations, paid claims history will be compiled and evaluated. Since the $14.10 is an estimated rate, it will be adjusted on May 1, 1995, for future periods so that payments will be budget neutral when compared to the old pricing system. In future years, the Medicaid rate will be increased based on economic trends and conditions.

CALCULATED FEE

Payment is Basic Value plus Time Values plus Modifying Factors times Medicaid rate.

Basic value, time values, and modifying factors are defined in the Relative Value Guide published by the American Society of Anesthesiologists. Time Values are added to the basic value at the rate of one unit for each twelve minutes or fraction thereof.

Obstetrical Anesthesia

Because obstetrical anesthesia is unique and an anesthesiologist may attend more than one patient concurrently under continuous regional anesthesia, there will be a reduction in the unit value after the first hour of anesthesia time. During the second hour of anesthesia, the unit value will be reduced by 50%. During the third and each succeding hour of anesthesia, the unit value will be reduced by 75%.

Modifying Units

Modifying Units may be added to the basic value where increased risk and special technical skills are involved or necessary for extremes of age (under one year or over 70 years), two modifying units may be added.

a. When anesthesia is administered under extenuating circumstances away from the operating room suite, 2 modifying units may be added.

b. Utilization of total body hypothermia, 5 units may be added.

c. Utilization of controlled hypotension, 5 units may be added.

42 CFR 440.60

F. PODIATRISTS

Payments are based on the established fee schedule unless a lesser amount is billed. The amount billed cannot exceed usual and customary charges to private pay patients. The fee schedule is described in section D "Physicians".